CENTRAL TEXAS
RETINA INSTITUTE

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**ALL INFORMATION MUST BE FILLED OUT TO ENSURE RECORDS ARE RELEASED**

**RETURN FORM TO STAFF OR EMAIL TO MEDICALRECORDS@ALAMORETINA.COM**

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____

Patient Address: _____ Phone #: _____

Date of Birth: _____ Social Security Number: _____

This is to authorize: _____

To disclose this information to: _____

address: _____

phone #: _____

fax #: _____

For the purpose of:

Medical Care: ☐ Work: ☐ School: ☐ Insurance: ☐ Other: ☐ _____

Please release the following:

Progress Notes: ☐ Lab Notes: ☐ Operative Reports: ☐ Visual Fields: ☐ Special Testing: ☐

Lab Reports: ☐ Medical History: ☐ Other: ☐ All: ☐

In the following format: Paper:☐ Flash Drive:☐ Email:☐ email address: _____

Records will be released promptly after payment has been received.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent any misunderstanding of the information contained in these entries. I will not hold Central Texas Retina Institute liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

If I have questions about disclosure of my health information, I can contact:
Daniel Castro, Privacy Officer, Central Texas Retina Institute

_____ _____

Patient Signature or Legal Representative Date

_____ _____

Witness Date

1100 North Main Avenue, San Antonio, Texas 78212 Phone: (210) 880-3000 Fax: (210) 227-6056